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Domestic violence teaching in UK medical schools: a cross-sectional study

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SUMMARY

Background: Domestic violence and abuse (DVA) is a leading contributor to the physical and mental ill health of women. Recent international guidance recommends that undergraduate medical curricula should include DVA. We do not know what is currently taught about DVA to medical students in the UK.

Method: Teaching leads from all UK medical schools ($n = 34$) were invited to participate in an 18-item online survey about what DVA education is provided, their views of this provision and any feedback provided by students.

Descriptive statistics were used to analyse the data.

Results: A total of 25 out of 34 medical schools participated in the survey (74%). All respondents felt that there should be formal teaching on DVA in the medical curriculum. Eighty-four per cent of respondents reported that there was some formal teaching in their medical school, and 90% of these reported that it was mandatory. Of those who delivered some teaching, 52% reported that the provision was 0–2 hours in total. Most commonly content was delivered in year 4. DVA teaching was delivered in different

modules, by different methods and delivered by a range of different providers. Seventy-five per cent of respondents reported that they felt the provision at their medical school was inadequate or not enough. Barriers to providing DVA education identified included time constraints, failure to perceive it as a medical problem and the assumption that it will be covered elsewhere.

Conclusion: Most medical students in the UK receive a small amount of teaching on DVA towards the end of the curriculum. This is perceived as inadequate.

Recent international guidance recommends that undergraduate medical curricula should include DVA

Survivors of DVA believe that their doctor is one of the few people they can disclose violence to

INTRODUCTION

The UK cross-government definition for domestic violence and abuse (DVA) is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'.¹ DVA is a leading cause of female morbidity and mortality globally, experienced by 35% of women worldwide.² Two women a week in England and Wales are killed by a partner or ex-partner.³ Although women suffer more severe and systematic DVA, men can be victims too. Exposure to DVA is associated with a significantly increased risk of a range of physical and mental diseases, including depression, anxiety, post-traumatic stress disorder, and gynaecological and sexual health problems.² Health systems need to respond to DVA: doctors are central to the identification, support and referral of victims.⁴ Survivors of DVA believe that their doctor is one of the few people they can disclose violence to and want them to respond appropriately.⁵ The National Institute for Health and Care Excellence (NICE) guidance in the UK from 2014 recommends that training on DVA should be part of the medical undergraduate curriculum.⁶

Surveys of DVA education provided to medical students have been conducted in the USA,⁷ Canada,⁸ and Australia.⁹ This study aimed to describe current UK medical education on DVA, including curricular content, delivery, views of its adequacy and any barriers to provision.

METHOD

We e-mailed primary care teaching leads from UK medical schools ($n = 34$) to invite them to participate in an online survey (Appendix S1), or to

forward our e-mail to potential participants who had knowledge of what was taught on DVA at their medical school. We asked participants to complete an online survey consisting of 18 questions on the provision of DVA education at their medical school, views on its adequacy and any feedback from students. The online survey was created by the authors, asking similar questions to those used by Hegarty and colleagues,⁹ and developed with feedback from medical curriculum colleagues at the University of Bristol, who tested the survey. In the two instances where more than one response was received from an institution, we combined the answers, where congruous, and clarified any discrepancies by e-mail. We used descriptive statistics to analyse quantitative responses in STATA and EXCEL. We grouped and summarised free-text responses using thematic analysis.¹⁰ The study was approved by the University of Bristol Faculty of Health Sciences Research Ethics Committee, and was funded by a grant from the Royal College of General Practitioners Scientific Foundation Board.

RESULTS

Twenty-five out of 34 medical schools participated in the survey (74%). One medical school declined to participate, and the remainder did not respond. There was a wide range of individuals

who completed the survey, including curriculum leads, lecturers, deans/sub-deans, clinicians and teaching fellows.

DVA education, content and delivery

Most respondents (21 out of 25, 84%) reported that their medical schools delivered some form of DVA education; four participants reported that there was none. Of the 21 medical schools that do provide some formal education on DVA, 90% described this as mandatory.

Of the medical schools that provide DVA education, 11 reported this to be 0–2 contact hours over the 5-year course, seven reported 3–5 contact hours and one reported 6–10 contact hours, but this was only available to a few students.

Most ($n = 13$) of the DVA education provided in UK medical schools is contained in 1 year of the course; eight of the medical schools provide DVA education across two different years.

As shown in Figure 1, DVA education is mostly delivered in the latter years of medical school.

Respondents reported a wide range of teachers, including clinicians, social workers, researchers, medical and non-medical academics, DVA specialist service providers and an e-learning website.

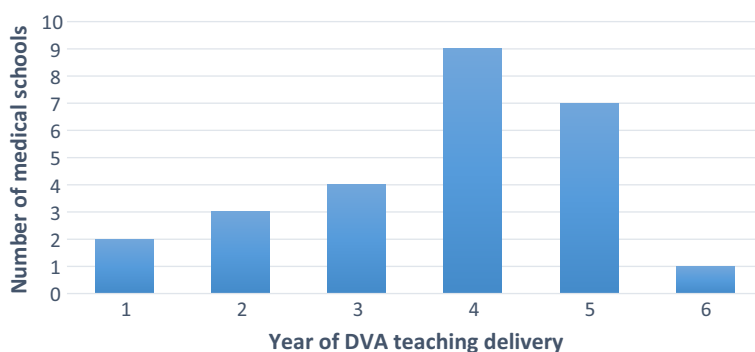


Figure 1. In what year of the curriculum is domestic violence and abuse (DVA) education provided? Note that UK medical school programmes vary in length from 4 years (with graduate entry) to 5 or 6 years

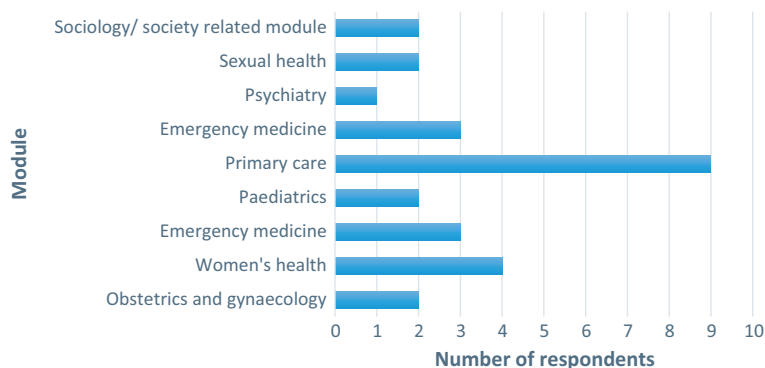


Figure 2. In what curriculum module is domestic violence and abuse (DVA) education provided?

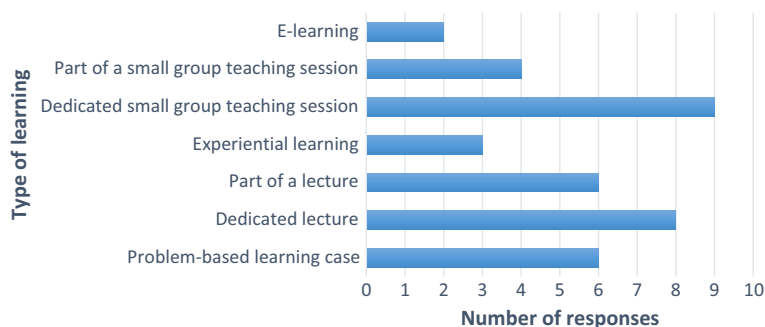


Figure 3. What type of learning experience is used for domestic violence and abuse (DVA) education?

Figure 2 shows the range of curriculum modules within which DVA education is delivered. The most common module for DVA education is primary care.

Figure 3 shows the wide range of methods used in DVA education. The majority of provision is either a dedicated small group teaching session or lecture.

Opinions on the provision of DVA education in medical curricula

All respondents answered that they thought that there should be formal teaching on DVA in the medical curriculum. The themes are summarised in Box 1.

Respondents from medical schools who do not provide any DVA education highlighted a number of possible reasons for this (Box 2).

Two respondents described a 'Hawthorne effect': the change of behaviour that results from the awareness of being studied, where participation in this study

has highlighted the lack of DVA education on the curriculum and has prompted a review of this.

Of the medical schools that do provide some form of DVA education, 15 respondents (75%) felt that the teaching provided at their institution on DVA was 'inadequate' or 'not quite enough'. Only three respondents felt that the teaching quantity was 'about right', and two answered 'don't know'.

The most commonly selected answer with regards to the methods used to prepare future doctors to identify and respond to DVA was 'there are ways it could be done better' ($n = 9$).

Elaborations on the above answer included wanting 'more time to be able to discuss cases', feeling it would be valuable to have a session where 'teaching is put into practice with actors', feeling that a 'structured approach to management' is missing and wanting to do the sessions in a small group rather than in lecture format.

Respondents felt that the teaching provided at their institution on DVA was 'inadequate' or 'not quite enough'

Box 1. Themes identified when asked 'Why do you think there should be formal teaching on domestic violence and abuse (DVA) in the curriculum?'

- A common, hidden, important problem
- DVA has a profound impact on health and public health
- A need for future professionals to be aware of DVA, be able to recognise, understand the issues and manage or refer
- Evidence that doctors haven't provided appropriate care to survivors of DVA
- Students request it

Box 2. Themes identified when asked 'Please provide any reasons why you feel there is no teaching on domestic violence and abuse in the curriculum currently'

- Not enough time in the curriculum
- It is on the 'wish list'
- Not perceived as a medical problem
- Only recently been identified as an issue to cover
- Assumption that this knowledge can be picked up elsewhere

There is a need to better understand how to prepare future doctors to be able to ask about and respond to DVA

Student feedback

Several participants anecdotally reported that feedback from students was positive. One participant shared formal feedback provided by students. The feedback was resoundingly positive, particularly with regards to appreciating a better understanding of DVA and what help is available, and feeling more confident to be able to assess and manage this in their future careers. They found the insight provided by survivors particularly 'powerful', and felt 'privileged' and 'inspired' by hearing their stories. The main theme that emerged for improving the education was requesting more time be allocated to the subject, with several students requesting a full day.

DISCUSSION

Strengths of this survey include the relatively high response rate and use of quantitative and qualitative data to establish the current profile of DVA education in UK medical curricula. A limitation was the heterogeneity of the respondents: trying to access the most appropriate respondent at each institution was a challenge. When seeking appropriate participants, it became apparent that although several teaching leads were not aware of any DVA education in the curriculum, they were often unsure whether it could be in another part of the curriculum and were therefore reluctant to complete the survey. Perhaps in some institutions where there was no DVA education, embarrassment may have been a reason for non-participation, and pride in good provision may have made an institution more likely to participate, and in more detail. Perhaps our data presented are skewed towards those schools that actively engage in DVA education.

Students in most UK medical schools are receiving up to 2 hours on DVA at one point in the curriculum, usually taking the

form of a small group teaching session or a dedicated lecture. The majority is didactic, rather than experiential, learning. Although experiential learning might be particularly powerful in this subject area,¹¹ it can present a logistical and ethical challenge to arrange the interaction of large numbers of students with survivors of DVA.

The majority of DVA education provided to medical students in the UK is confined to 1 year of the medical curriculum, and tends to be delivered in the latter years of the course. There is an argument that it could be more beneficial for students to engage with this topic area when they have experienced more patient contact. As highlighted by one respondent, perhaps exposure earlier in the course would enable earlier disclosure by students who have or are being affected by DVA, and who may benefit from support.

A wide variety of professionals deliver teaching on DVA to medical students. DVA is a relatively new topic in medical education; many medical educators may not have received any training on DVA themselves. As found in the study of DVA in Australian medical curricula,⁹ it is likely that the influence of a 'local champion' at a university correlates with the presence of DVA education. This is supported by the more positive responses of those with more comprehensive provision in this study.

CONCLUSION

We have shown that there is considerable variation in what education UK medical students are receiving on DVA, which was similarly found in surveys conducted in the USA, Canada and Australia. DVA has a profound impact on health, and survivors of DVA would like to be able to talk to their doctor about abuse.

The NICE guidelines recommend that we should be teaching on DVA, and teaching leads report that the current provision is not enough: medical education must step up to the mark.

There is a need to better understand how to prepare future doctors to be able to ask about and respond to DVA. It is recommended that at each medical school this is developed with local expertise, such as DVA support services, input from survivors, other medical schools with experience of DVA teaching, national clinical guidance (such as NICE⁶) and medical students who are engaged in the issue. Less than 2 hours of teaching time is inadequate when the morbidity and mortality of DVA are considered. Patients who have experienced DVA present in any medical specialty; DVA education would ideally be best encountered at a number of points through the curriculum,⁷ allowing the student to benefit from the iterative nature of spiral learning, increasingly valued in medical education.¹²

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DVA education would ideally be best encountered at a number of points through the curriculum

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article at <http://onlinelibrary.wiley.com/doi/10.1111/tct.12706/supinfo>

Appendix S1. Questionnaire.

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